desensitisation in the UK is wrong and needs to be changed. It is used to treat disorders (such as asthma in adults) and against allergens where there is no convincing evidence for its efficacy. This is irresponsible in view of the potential risks. We now have drugs, particularly topical steroids, which give excellent control of symptoms in most patients and have revolutionised treatment. If desensitisation was (*a*) not used as first line therapy in allergic rhinitis and (*b*) considered only in conditions where it is of proved value few patients would need to be given it.

Convincing evidence of efficacy in double blind placebo controlled trials exists for ragweed hay fever[1] (a problem in the USA) and allergy to bee and wasp venom[2] (but only when pure venom extracts are used) and probably for grass pollen allergic rhinitis.[3] A single study of a small number of patients does not necessarily provide convincing evidence of efficacy. In the case of insect sting allergy, although there is no doubt about efficacy, the indications for giving immunotherapy are controversial[4] and practice varies widely. In house dust mite allergy in adults conflicting results have been obtained,[5-8] but overall there is no convincing evidence of efficacy. While there is some evidence of efficacy in children,[9,10] the indications for its use in children are unclear. This allergen is a major problem, being the commonest cause of perennial allergic rhinitis in the UK. A further problem is that even when "efficacy" has been shown there is no study showing long term cure. This is confirmed in clinical practice, where improvement on desensitisation usually means reduction in symptoms, not cure, and this is not a long term effect. Since effective antiallergic drugs have become available, long term cure must now be the main aim of desensitisation.

In spite of the absence of evidence of the efficacy of house dust mite extracts in the treatment of allergic asthma, these preparations are often given. It is important to note that of the 26 deaths from anaphylaxis mentioned in the CSM report, 16 were attributed to desensitising vaccines given as treatment for asthma. These patients therefore died as a result of inappropriate therapy. The CSM report does not state how the reactions were treated, possibly because the information was not available. The immediate use of adrenaline is usually highly effective in anaphylaxis, but it is often not given until antihistamines and steroids have been tried, by which time the patient may be moribund.

There is a place for desensitisation therapy, and if extracts of proved value are used appropriately in carefully selected patients and administered by doctors and nurses with experience most severe reactions and deaths could be avoided. The CSM statement is likely to lead to a virtual ban on the use of desensitising vaccines, whereas what is needed is critical reappraisal. The lack of specialists in allergy compounds this problem.

Finally, the CSM update states there is "convincing evidence of efficacy" for "vaccines used to protect against anaphylaxis induced by some antibiotics." We are not aware that this is an accepted practice of proved efficacy and would like to hear further evidence from the CSM on this point. No such product is licensed in the UK.

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SIR,—The update from the Committee on Safety of Medicines on desensitising vaccines reported 26 deaths from anaphylaxis induced by these agents since 1957, with an apparent increase in frequency since 1980. The information is disturbing and the CSM is right to draw our attention to it. We are concerned, however, about the possible consequences of its recommendations.

Their information indicates that asthmatics are particularly at risk of developing anaphylaxis and bronchospasm. Since there is no good evidence yet that desensitisation ameliorates asthma, most responsible practitioners would not normally use this form of treatment in asthma. It is likely, too, that adequate precautions, such as adrenaline and hydrocortisone already drawn into syringes and supervision for at least 30 minutes, are by no means always observed in general practice, where the vast majority of desensitisation takes place. In addition, it is probable that polyallergic patients have been injected with mixes of multiple allergens, a regimen which is extremely unlikely to result in a beneficial outcome. All of these factors, together with a paucity of information from controlled trials, weight the risk-benefit equation away from desensitisation treatment.

There is clearly an urgent need for controlled trials of the effects of desensitisation. The British Society for Immunology might well be the body to coordinate this, possibly with funding from the Medical Research Council or the pharmaceutical industry.

Our concern is that even properly selected and supervised desensitisation treatment may now be regarded as suspect by referring doctors and patients, and that the necessary research to clarify the situation may have been compromised by the CSM's recommendations. We suggest that further discussion between the CSM and appropriate specialists should take place, which may lead to alterations in the present recommendations.

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Doctors and the drug industry

SIR,—May I thank Dr Richard Smith for his concise review (11 October, p 905) of the relationship between doctors and drug companies. The issue is indeed pressing. Clear thought and honest practice in the matter are hampered both by the apparent acceptability and normality of the present relationship and by failure to appreciate the special role, in commercial terms, played by the prescribing doctor.

Drug companies' "hospitality" is so widely accepted that doctors who do not eat drug lunches are thought odd or unsociable: if the drug lunch becomes a weekly social event in a hospital the pressures to participate and partake are great. But, as the Royal College of Physicians committee says, drug lunches do indeed degrade doctors. Surely we are well enough paid to buy our own food and retain the possibility of independent assessment of drug company products. There is no such thing as a free lunch—on *either* side: for the events also degrade the companies and cast doubt on the value of the products promoted. A good drug hardly acquires its value from the admixture of Muscadet and smoked salmon quiche.

But, it is said, this hospitality is simply normal commercial and business practice. There is, however, a major difference between the doctor-company relationship and the advertising of soap powder to the great clothes washing public. Doctors are not spending their own money but that of the payers of tax and prescription charges. They act, therefore, as buyers or agents. The person affected by the decision is not the prescriber. How much more, then, should we be making decisions unaffected by company "hospitality."

Doctors should be clear on these matters. We do not need gifts from the drug companies—ball point pens or Mediterranean holidays. Meetings to promote drugs should be just that—but our principal sources of information on new and old drugs should be the *British National Formulary*, the *Prescribers' Journal*, and unsponsored reviews and research. Our patients and our professions cannot, ultimately, but benefit.

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SIR,—Dr Richard Smith's leading article was very critical of drug company lunches, dinners, teas, and sponsorship. These activities are accepted as harmless and not very important by most GPs. It is certainly in the interests of the advertising men that their hospitality is not taken too seriously or looked at too closely. Dr Smith concentrated on the bribery and corruption issue, and I think there is another important problem to be considered—the debilitating effect on the intellectual activities of GPs. When the status of learning for learning's sake has sunk so low that it has been renamed "postgraduate education" in horrid contemporary jargon I think we should worry.

A large proportion of the "education" of GPs takes place in the context of drug company hospitality of some sort. GPs, lured to a talk by a learned colleague, or more usually a company representative, take part with about as much dignity as a school child lured to do homework by promises of sweets or television programmes. The example set to young doctors is, "Only do it if you can get a free meal," and the moral for the savant is, "They'll only listen if you pay them." Why does it matter? Advertisements are a feature of most aspects of life, are they not? In fact we like to keep them out of things we think are really important, like unspoilt countryside and religion.

The drug company representatives do not deserve a life on the dole any more than steel workers or miners. To earn a crust they have to eat anonymous restaurant meals with strangers with whom they have to feign friendship, instead of in the intimacy of their own families. Family doctors should be the last people to encourage this sort of domestic disruption. One of the saddest aspects is that the real draw of the drug company dinner is probably the conviviality rather than the free meal. But alas for anyone who values friendship for its sincerity, or learning for its own sake. Most of us can live with very little dignity. We can live with the knowledge that we are being given a meal which many of our patients could not afford but which they would appreciate much more.